**Welcome to CHC Continuity Clinic 2019-2020**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| Preceptor | Christine BriccettiKaren FratantoniMelissa Long | Dale CoddingtonCara LichtensteinYael Smiley | Dan FeltenEd FoxJenny Tender | Cara BiddleRuth HolloFrancesca Joseph | Rebecca CarlinLinda FuNazrat MirzaSarah SchafferDeRoo |
| PL1 | Andrew MeyerJillian SmithR | Nada AlabdulkarimJohn IdsoKirkland WilsonG | Alexander DaigleHayley SparksMrinmayee TakleN | Paige KennedyAmy LawEllizabeth PickupN | Molly ClarkeOlusegun OwotomoRSara Alhousseiny |
| PL2 | Nouf AlsaatiKaitlyn BoggsMejdi NajjarN | Morgan KendallMolly MoehlmanNIsabelle Riley | Zhour BarnawiClaire MaggiotoAlice Shanklin | Andrea CohenGLena SalehNouf Alaqla | Shaefali ShandilyaDane Stone |
| PL3 | Stephen OvercashAyesha Sulaiman | Aaron PhillipsLisa Rickey | Mary MottlaKevin Lloyd | Caitlin CutlerLiz Elliott | Michael AmbersonLana MukhareshMatthew Sherman |

Resident “Tips” about CHC continuity clinic

“Be Patient- It takes a while to learn how things work in clinic, especially if you don’t do your block time until later in the year”

“Get to know about all the different resources available to our patients”

“Use the CHC resident schedule to schedule patients to follow up with you. It’s great to have continuity with your patients and families” “If you will be away and a family needs to come back; Schedule with another resident in your clinic- some our families have 2 clinic residents that know them well.”

“There is lots of change that happens in CHC. Don’t be surprised if you are a way for a couple weeks and there is something new. The clinic is always trying to improve care for patients”

“Minimize walking back and forth. Go in to a Well Child check up with the Reach out and Read book, school excuse slips, Bright Futures handout. Know what is available in the rooms and what you can put in orders for the nurses to do such as school forms and asthma action plans”

“Everyone here works together as a team. If you have an idea about improving something- talk to your preceptor about it”

“You’ll learn something new every time you’re in clinic- About patient care, new resources, billing etc.”

First Day Activities

Introductions, orientation and tour

Does your ECW password work? Log into ECW and have an ECW overview by attending. Learn how to merge a template (WCC templates, asthma templates)

Shadow a second or third year resident. Take a computer in with you.

**CHC CONTINUITY CLINIC ORIENTATION**

Welcome to Children’s Health Clinic (CHC). Over the next three years you will follow patients and families as their primary care physician and will provide well child care, chronic disease management and acute illness care. We see children birth- 11 years currently. When the clinic moves into the community (anticipated move summer 2020), you will be seeing patients birth -21 years old.

**The Schedule**

Conference: 1:05 -1:30. Please be on time. If you will be late, page your preceptor or call x2953. We will cover basics of well child care, immunizations and common pediatric illnesses in the first six months. The residents will give some of the conferences (PL1 – 1-2 conferences/ year, PL2&3- 2-4 conferences/year)

Please check Resident Book (Goldberg Continuity Clinic) for the topic for the weekly conference and a reading on the topic to review ahead of time.

Patients: 1:30 to 5-6 PM (scheduled patients and walk-in illness visits). The afternoon team of residents, attendings and nurse practitioners sees the patients who arrive before 4:40 and have vitals before 5 pm.

CHC is open Mon -Thurs 8 am- 9 pm (last patient in by 8 pm), Fri 8am – 5 pm and Sat 9 am- 5 pm (last patient in by 4 pm). Attending physicians and nurse practitioners staff the clinic during the evening and Sat hours.

**Supervision**

You will present each patient in the first six months you are here and we will go in to see the patient as well. There’s a lot that goes on here that they never teach in medical school. Ask lots of questions! We also want to observe you interacting with patients so we can give you feedback. We will come in to do brief observations (and will complete a SCO form for you).

In January, you will be asked to give a “One sentence summary” of each patient. This is often more than one sentence and should include your assessment and plan for the patient and any questions you have for us. We will not necessarily go in to see each patient but we will if you have a question about a physical finding, the patient is ill appearing or has an unusual history or the patient is medically complex and you spent more than 20 minutes with them.

Feel free to contact your preceptor by e-mail (best way) or pager if you need help before your next clinic with a continuity patient (ie: regarding a phone call, abnormal labs etc). Don’t forget to check your message and lab Jelly-bean in ECW.

**Expectations for Patient Care**

**Every Visit**- Every visit you need to ask about current medications and **do medication reconciliation (check the box). You also need to ask about allergies**. Please also check to see if the patient is up to date with their well child care and their immunizations. Our clinic policy is to immunize patients who are behind at illness visits and then schedule them for a well-child checkup.

Health Supervision visits: Well child care requires complete interval history, including nutrition, sleep, behavior, and risk screening. Past medical history, medications, allergies, family and social history should also be reviewed. PE for children should be complete, including genital, neurologic and developmental exam.

Visits for illness: History of present illness (including who is the primary care doctor), brief review of systems, past medical history (including immunization status, *allergies and medications)* and pertinent family history are to be done and recorded. PE should be focus-based, with an emphasis on the chief complaint but should include all pertinent systems.

Tips to make a visit more efficient: Once a patient is in a room, all care will occur in the room including immunizations, treatments.

Start by reviewing the problem list & what immunizations are needed and order them (you can check with the preceptor before going in the room). You can order completion of school forms, asthma action plans, spacer teaching, epi pen teaching and lactation consults and our nurses will do those. It speeds up the visit if you let the nurse come in during the visit to do the immunizations. Once you have your nursing orders in – Flip visit status to “OrdHold” to notify the nurse that s/he can come in to do the orders.

We’ll show you how to print out a visit summary that will have instructions for the family. Next visit should never be PRN – it specify next WCC, asthma f/u etc.

**Number of Patients Seen Per Session**

You’ll have 3 patients on your schedule each afternoon as a PL1. Doesn’t sound like much, but you are learning a new system: paperwork, logistics, as well as the stuff of medicine. Be patient with yourself. Learning to get through the afternoon in an efficient manner is a big goal of the first year.

Residents are scheduled for PL1- 3 patients/ session, PL2- 5 patients/session, PL3- 6 patients/session.

The Residency Program expectation is that the average number of patients per session in continuity clinic at a minimum will be PL1= 3, PL2= 4, PL3=5. Try to see at least that many patients every session.

You will have “No show” patients. In that case you should look to pick up a walk in patient or see if one of your fellow residents needs help with their schedule. Your preceptors will help manage the schedule and help you know which patient to pick up next. The attending physicians and nurse practitioners are schedule for 12 patients a session. At times there will be patients who come in late but need to be seen “Same Day Late” patients. They will be seen by any of the providers who have availability due to no shows including the attending physicians, nurse practitioners and pediatric residents

**Developing continuity with patients**

You will gradually start to see the same patients back for visits and develop continuity with a group of patients that consider you their doctor. We don’t set up a special panel for you-it’s all about forming those relationships and fostering them. If you are seeing someone back again in the next couple months, you can book their appointment in ECW as long as your schedule has been opened (if the schedule isn’t open yet, you can book on the “CHC resident schedule” with a note to schedule with you). Consider making business cards to give patients or making yourself a telephone reminder to schedule their appointment to see you. If one of your patients misses their appointment, call them or send a telephone encounter to the Call Center to ask them to reschedule the patient with you.

**Documentation of Patient Care/ Clinical Skills**

**1) Keeping a log** of continuity clinic patients is a requirement of the residency program. Update your EXCEL log regularly. For patient privacy don’t use names, use the last 5 digits of the medical record.

**2) Procedure Log-** Don’t forget to log your procedures such as: Removal of foreign body, giving IM and SQ injections, urine caths.

**3) SCO forms**- Your preceptor will observe your interactions with patients and give you feedback using the SCO form. Please be pro-active in asking to be observed –the goal is learning. The minimum number of SCO required is 4/year.

**4) Referral SCO**- You will need to do at least 2 a year. These are referrals that have been discussed (usually new referrals). Referrals to psychiatry or psychology are included. Think about what is your question for the specialist. Does the family understand the reason for the referral? What barriers might there be for the family making it to the appointment?

**Goals and expectations: what should I be learning here?**

You are here to learn the basics of outpatient general pediatrics. Focus on these key areas in your first year in clinic:

 1) **The basics of well child care visits**: the schedule of visits, anticipatory guidance to cover in those visits, screening tests (rationale, schedule, and interpretation), developmental surveillance/screening, and immunizations.

2) **Common childhood illness management**: asthma, otitis media, pharyngitis, upper respiratory infection, gastroenteritis, urinary tract infection, fever in infants & children < 2

3) **Communication skills**: gathering and providing information in a fashion sensitive to families and patients of all backgrounds and circumstances

4) **Demographics/characteristics of the patients** that come to your clinic

What type of insurance do we accept? What geographic area of the DC metro area do your pts come from?

5) **Office management in your practice and community resources**

**Reading and Learning**

A good book to have for well child care is- Bright Futures (<https://brightfutures.aap.org/>)

In Resident Book – Under Teaching and Learning Resources

- **Children with Special** **Needs** (an on-line course with information about Medical Home and Community Resources and Care Plans)

- **Clinic Resources** (key articles and some PowerPoint)

- General Pediatrics (**Breastfeeding videos** for physicians and parents)

Find out about the John Hopkins and Yale modules in Resident Book under Continuity Clinic- they are also good resources for learning

**Children’s Health Clinic as a Medical Home**

We strive to make our clinic a medical home for our patients. A medical home offers accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective care. ([www.medicalhomeinfo.org](http://www.medicalhomeinfo.org))

We recognize that there is a tension between being accessible and being efficient. Vaccinating children during illness visits sometimes creates flow issues but improves vaccination rates for our patients. Seeing walk-in patients results in patients being seen who might otherwise not get needed care, but can make you late seeing your next patient. We welcome your ideas on improving the clinic.

We are a team- each session you will have a PCT and nurse assigned to work with you. Our nurses do school forms, asthma action plans, asthma teaching and lactation consulting as well as immunizations, medications etc.

**CHC Resources for caring for patients**

“The Card”- immunization and screening recommendations based on AAP guidelines.

On site social worker- Alison Page (ext 3556) & a family service associate

Case Managers- (Leslie Hollowell, Allegra Burrell, LaNetta Wilson)

Parent Navigators- Parent support for families with children w special health care needs

Nutritionist is at CHC weekly on Tues am

Psychologists are available for intakes, short term counseling and to help with referral to services.

Psychiatrist is available on Tues pm to do consultations and short term management

Child Law Center- free legal advice for patients and families who live in DC

Generation Program- Teen parent (age < 18 yr.) and child clinic

Complex Care program for children with complex or tech dependent medical needs (many have a community pediatrician and come to Complex Care for care coordination

IDEAL clinic for obese children

Sports Medicine Clinic with Dry Coleman in AHC on Thurs pm (will see school age pts.)

Lactation consultants ( nurse lactation consultants)

On site breast pumps (depends on the mother’s insurance)

Reach Out and Read- books for every well child visit 6 months- 5 years old (and sometimes beyond)

Asthma supplies including on site spacers, peak flow meters and nebulizers.

D.C Immunization Registry – nurses can view immunizations

Pediatrix website- On-line results of newborn screens for babies born in D.C.

Translator telephones for non-English speaking families

**Our patients at CHC:**

~35,000+ patient visits/year

~ 80% or more live in DC; most of the rest are from bordering counties in Maryland

~ 85-90% insured through Medicaid/CHIP program (up to 200%poverty)

High number of children with special health care needs who get primary care from us and specialty care through Children’s as well.

HSCSN is a Medicaid HMO in DC for children on SSI disability.

REM is a MD Medicaid program for children with special needs.

**Learn about children in DC**: <http://datacenter.kidscount.org/>

For Resources: <http://dchealthcheck.net> (lots of resources for providers)

**Rotation Objectives**

1. Provide age-appropriate pediatric well child care (including history, physical, screening tests, immunizations and anticipatory guidance).
2. Develop evaluation and treatment plan for patients with common acute illness complaints &/or conditions (for example fever, wheezing, abdominal complaints, and rash).
3. Develop an evaluation & treatment plan for patients with behavioral, developmental, or mental health concerns.
4. Develop and update treatment plans for patients with chronic conditions including screening, referral to community resources, consultations, management of complications (for example- asthma, obesity, allergic conditions, cerebral palsy, seizure disorders, sickle cell disease)
5. Coordinate care with community providers (early intervention, school, insurers, care managers, nursing agencies) and resources (legal, family support, respite)
6. Manages the referral and consultation process.
7. Provide effective teaching to peers, students, patients and families.
8. Demonstrate the basics of practice management including accurate coding and billing, referral of patients to appropriate resources and timely completion of medical record.

**Common Sub-competencies that you will also be evaluated on**:

9. Incorporate formative evaluation feedback into daily practice

10. Humanism, compassion, integrity, &respect for others; based on the characteristics of an empathetic practitioner

11. A sense of duty and accountability to patients, society, & the profession (include timeliness, charting, f/u of patients & labs)

12. High standards of ethical behavior which includes maintaining appropriate professional boundaries Professional Conduct

13. The capacity to accept that ambiguity is part of clinical medicine and to recognize the need for and to utilize appropriate resources in dealing with uncertainty

14. Work in inter-professional teams to enhance patient safety and improve patient care quality

15. Self-awareness of one’s own knowledge, skill, and emotional limitations that leads to appropriate help-seeking behaviors

16. Identify strengths, deficiencies, and limits in one’s knowledge and expertise

17. Identify and perform appropriate learning activities to guide personal and professional development.

18. Advocate for quality patient care and optimal patient care systems

Children’s National residency program uses “milestone” evaluation.

|  |
| --- |
| **CHC Schedule 2019/20****Flu for all children >6mos (Sept- April).** |
| ***Age*** | ***Immunizations*** | ***Health Maintenance.*** |
| 1st | Enter in ECW: Birth Hep B #1 | Check Newborn Screen results. Start Vit D if Breast feeding Do 2nd NMS if born in MD |
| 2 wk |  | Edinburgh Depression screen  |
| 1 M |  | Edinburgh Depression screen |
| 2 M | #1-DTaP, IPV, HIB (Pentacel), Hep B, Prevnar 13, Rota\* | Edinburgh Depression screen |
| 4 M | #2-Pentacel, Prevnar, Rota \* | Edinburgh Depression screen Poly-vi-sol with iron if BF |
| 6 M | #3-Pentacel, Hep B, Prevnar, Rota\*  | Edinburgh Depression ScreenReach out and Read (ROR) |
| 9 M | Catch up Imms? | **ASQ, Lead, Hb** (POC)Oral Health Screen/Fluoride |
| 12  | Varicella, MMR, HepA, Prevnar #4. Option-DTaP, HIB (Pentacel) if >6 mos since DTaP#3 | Lead, Hb (if not done at 9 mos)Begin Poly-Vi-Sol/ IronOral health screen/FluorideDental referralInstrument vision screen\*\* |
| 15  | #4-DTaP, HIB if not had prior | Oral health screen/Fluoride |
| 18  | HepA #2 (if 6 mos from Hep A#1) | **MCHAT,ASQ Dev. Screen**Oral health screen/Fluoride |
| 2 Yr | Hep A #2 (if not given at 18 mos) | **Lead , Hb** (point of care), BMI**MCHAT, ASQ-SE**Oral health screen/FluorideInstrument vision screen \*\* |
| \*Rota#1 if < 14 6/7 weeks, No dose after 8 mos, 0 daysReach out and Read book at WCC- 6 mos to 5 years |
| 2 ½  |  | **ASQ Dev. Screen,** BMIOral health screen/Fluoride |
| 3 Yr |  | **ASQ-SE**, **BP annually**, BMI, Instrument vision\*\*  |
| 4 Yr | Kinrix (DTaP #5, IPV #4), Proquad(MMR/Varicella #2 | Instrument Vision\*\*, Hearing, **SDQ**, BMI, BP |
| 5 Yr |  | Vision\*\*, Hear, **SDQ**, BMI,BP |
| 6 Yr |  | Vision\*\*, Hear, **SDQ**, BMI,BP |
| 7 Yr |  | **SDQ**, BMI,BP |
| 8 Yr |  | Vision\*\*, Hear, **SDQ**, BMI,BP |
| 9 Yr | HPV may be started (2 dose series) | Blood lipid panel, BMI,BPSports clearance , **SDQ** |
| 10 Yr |  | Vision\*\* , Hearing, **SDQ,** BPIf BMI> 95%- get Gluc, HbA1C,AST,ALT, Lipids |
| 11 Yr | Meningitis (Menveo or Menactra), TdapHPV (if not had) | **SDQ**, BMI, BP, Lipid panel if not done, Sports Clearance |
| **Verbal Chol. Screen** **Yearly** **> 2 yr:** Lab if High Risk.**Lipid Panel for all once btw 9-11 yrs**.**Blood lead age 9 mos &2yr ,**yearly verbal screen until age 7 **TB risk verbal screen yearly**, PPD if high risk, can use Quantiferon Gold if age > 2yrs (per CDC)**Sports Clearance-** annually from age 9 yo, sooner as needed**Food Insecurity Screening** annually**\*\*Vision-** Refer if< 6 yo & >20/40 **OR** >6 yo & >20/30) **For Patients with Sickle Cell Dz/Imm. Deficiency**-Menveo at 2,4,6,12 mos-Age 2- Pneumo23 (repeat in 5 yrs), MCV4 (2 doses:  8 weeks between- do not need if got Menveo series)-Age 10- Men B vaccine |